

Case Number:	CM14-0092849		
Date Assigned:	07/25/2014	Date of Injury:	10/07/2008
Decision Date:	09/16/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/19/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 65-year-old male who reported an injury on 10/07/2008. The mechanism of injury was a slip and fall. The diagnoses include status post left shoulder rotator cuff repair and subacromial decompression. Previous treatments include medication and surgery. Within the clinical note dated 04/25/2014, it was reported that the injured worker complained of ongoing mild to moderate pain in the left shoulder. He rated his pain at a 6/10 to 7/10 in severity. Upon the physical examination, the provider noted the injured worker's range of motion of abduction was 170 degrees, flexion at 160 degrees with internal rotation bringing his thumb to T11 and external rotation at 45 degrees. The injured worker had a positive impingement and empty can test. The injured worker had a positive Hawkins maneuver. The provider noted the injured worker to be neurovascularly intact in both upper extremities. The provider requested Norco for pain. However, the Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

RETRO: Norco 10/325mg, QTY: 120 (DOS: 04/25/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for retro Norco 10/325 quantity 120 date of service 04/25/2014 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation, pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screener in patient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of the urine drug screen was not provided for clinical review. The provider failed to document an adequate and complete pain assessment. Therefore, the request is not medically necessary.